Dental & Health History *CONFIDENTIAL*

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? ________________
How often does your child floss? ________________
Is your child's water fluoridated? ☐ Yes ☐ No
Does your child take fluoride supplements? ☐ Yes ☐ No

Does your child:

- Suck thumb/finger ☐ Yes ☐ No
- Suck/Bite lip ☐ Yes ☐ No
- Bite/Chew nails ☐ Yes ☐ No
- Chew hard objects (pencils, etc.) ☐ Yes ☐ No
- Grind teeth ☐ Yes ☐ No
- Clench jaws ☐ Yes ☐ No

Previous dentist ________________ Address ________________

Date of last dental visit? ________________

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Child's physician ________________ Address ________________

Phone # ________________

Previous Hospitalizations/Surgeries/Serious Illness? ________________ When? ________________

Is your child currently taking medications? ☐ Yes ☐ No (if yes, please list) ________________

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? ☐ Yes ☐ No (if yes, please describe) ________________

Does your child have a history of allergies to any other substance (latex, environmental, etc.)? ________________

Has your child ever had any of the following:

- Asthma ☐ Yes ☐ No
- Cancer ☐ Yes ☐ No
- Hepatitis ☐ Yes ☐ No
- HIV/AIDS ☐ Yes ☐ No
- Hemophilia ☐ Yes ☐ No
- A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ Yes ☐ No
- Abnormal Bleeding ☐ Yes ☐ No
- Stomach, liver or kidney problems ☐ Yes ☐ No
- Handicaps/Disabilities ☐ Yes ☐ No
- Tuberculosis ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- Rheumatic Fever ☐ Yes ☐ No
- Congenital Heart Defect ☐ Yes ☐ No
- Heart Murmur ☐ Yes ☐ No
- Convulsions/Epilepsy ☐ Yes ☐ No

Please explain any medical problems that your child has: ________________

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I have received a copy of this office's Notice of Privacy Practices.

________________ ________________
Signature of patient or parent if minor   Date

Dentist Review:

________________ ________________
Signature of Dentist   Date